



SUPPORT Act Grant

101:18

SUD & Legal Involved
Clients

PAUL BRASLER, M.A., M.S.W.

LICENSED CLINICAL SOCIAL WORKER

Copyright

- ▶ This material is copyrighted by Paul Brasler, LCSW, Behavioral Health Addiction Specialist, Virginia Department of Medical Assistance Services
- ▶ This material is to be used only by organizations receiving technical assistance through the SUPPORT Act Section 1003 Grant
- ▶ No reproduction, distribution, posting or transmission of any of this material is authorized without the expressed consent of the author
- ▶ **Last revision: August 6, 2020**

Disclaimer

- ▶ The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of use, and other things
- ▶ Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients

Questions?

If you have any questions, please do not
hesitate to contact me

paul.brasler@dmass.Virginia.gov

SUPPORT Act Courses

~~1: Tele-Behavioral Health in the Time of COVID-19~~ (No longer available—Incorporated into all courses!)

2: Client Engagement

3: Suicide

4: Crisis & De-Escalation

5: Withdrawal Syndromes & Withdrawal Management

6: Trauma-Informed Care

7: Overview of SUD

8: Opioids & Stimulants

9: SUD Treatment Basics

10: Screening & Assessment

11: Co-Occurring Disorders

12: Individual Therapy Skills

13: Group Therapy Skills

14: Addressing SUD Bias & Building Provider Empathy

15: SUD & Cultural Humility

16: SUD Treatment & the Family

17: Alcohol & Cannabis

18: SUD & Legal System-Involved Clients

19: SUD & LGBTQ+ Communities

20: “Novel” Substances of Use

Program Content

- I. Clients Involved in the Legal System
- II. Case Management
- III. Medication-Assisted Treatment
- IV. Drug Screening
- V. SUD, Legally-Involved Clients and Medicaid
- VI. Tele-Behavioral Health Basics

Language

- ▶ I believe in using “Person-Centered language” as much as possible, thus:
 - ▶ Not “Addict,” but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
 - ▶ Not “Addiction,” but **Substance Use Disorder (SUD)**
 - ▶ Not “Clean,” but **In Recovery** or **Testing Negative**
 - ▶ Not “Dirty,” but **Testing Positive**
- ▶ At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms
- ▶ Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc.

Two Important Things You Must Do Before Working With Any Client

- I. **You must care!** You must like people in general regardless of their circumstances, behaviors or opinions of you
- II. **Find something to like** in the person you are working with—connect with them on a human level



NO ONE
*sets out to
become
addicted to
chemicals or
behaviors*



Addiction Defined: ASAM

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

Recovery Defined

“...A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life.”

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)





Stigma Defined

“Stigma is a social phenomena whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly”
(Avery & Avery, 2019, p. 94)

Why Is This Important?

Remember what we started with: People matter, regardless of what they are going through

Stigma is one of the main reasons that people with SUD do not seek treatment



Clients Involved in the Legal System



Over 2 million Americans have Opioid Use Disorder

1 in 3 people with OUD are arrested each year

56 – 90% of people who inject drugs have been incarcerated previously (ASAM, 2020, p. 60)

1 in 5 incarcerated individuals are held for drug-related offenses

1 in 3 state prisons offer some form of evidence-based treatment

1 in 100 jails offer evidence-based treatment



Justice-Involved Members with SUD

(Joudrey et al, 2019)

Clients Released From Incarceration

- ▶ Clients can readily obtain illicit chemicals and other contraband in most jails and prisons
- ▶ There is a substantial increase in death rates during the first two weeks following a client's release from long-term incarceration, with overdose being the most common cause of death (Joudrey et al., 2019)
 - ▶ Much of this can be attributed to the client's tolerance decreasing while incarcerated and resumption of use of possibly unfamiliar substances
- ▶ Efforts are being made to engage clients (especially those with mental health and/or SUD) in a variety of ways while they are still incarcerated to help them better transition to life outside a prison or jail



Assess the individual's clinical and social needs and public safety risk



Plan for the treatment and services required to address the individual's needs, both in custody and upon reentry



Identify required community and correctional programs responsible for post-release services



Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

SAMHSA's APIC Model (2017)

Problems Faced by Recently-Released Clients

- ▶ Lack of coordination between correctional programs and community-based programs continues to be a major problem
- ▶ Released individuals often have difficulty:
 - ▶ Obtaining housing
 - ▶ Getting their driver's license restored
 - ▶ Obtaining financial assistance
 - ▶ Getting mental health, dental, SUD treatment and medical services
 - ▶ Obtaining insurance
 - ▶ Getting a job

Why Does This Matter?

- ▶ 4.5 million people are on parole/probation in the U.S.
- ▶ When incarcerated, the jail/prison has a Constitutional requirement to provide medical care, but this does not continue when the client is released
- ▶ When released, and with limited resources, many of these clients:
 - ▶ Face a higher mortality rate, especially in the first two weeks following release (overdose, homicide, suicide)
 - ▶ Wind up in emergency departments
 - ▶ Are more likely to be re-detained
- ▶ This leads to:
 - ▶ Higher costs for care and/or subsequent incarceration
 - ▶ Continued trauma within families



Case Management

Case Management

- ▶ Case management (sometimes called care coordination) is an integral part of any level of SUD treatment
- ▶ All therapy usually includes some case management
- ▶ The primary goal of case management is to help clients connect with services and resources that enhance their treatment
- ▶ CM is helping the client learn to access the things they need instead of doing things for the client that they can do for themselves
- ▶ It is vital that clinicians remain aware of up-to-date services within their clients' communities

Personal Recovery Capital:

The client's physical health, emotional supports and things that support recovery (housing, income, insurance, food, safety)

Family/Social Recovery Capital:

The resources and support available to the client from their family and friends (emotional, financial, help with childcare, transportation)

Community Recovery Capital:

Resources available in the client's community (healthcare, childcare, transportation, housing, etc.)

Case
Management:
Building on
Recovery
Capital

Some Case Management Needs

- ▶ Medical appointments
- ▶ Medical treatment
- ▶ Obtaining health insurance
- ▶ Dental care
- ▶ Transportation
- ▶ Childcare
- ▶ Job search
- ▶ Housing
- ▶ Enrolling in job training
- ▶ Legal aid
- ▶ Meeting legal system obligations (coordinate with probation/parole)
- ▶ Financial assistance
- ▶ Obtaining food vouchers
- ▶ Access food pantries
- ▶ Clothing
- ▶ Enrolling children in school
- ▶ Immigration needs
- ▶ Additional mental health needs

Medication-Assisted Therapy

The background of the slide features a medical-themed image. It includes a blue stethoscope resting on a blue surface, a white pen, and several white and green pills. A white pill bottle is partially visible in the upper left corner. A large, semi-transparent teal circle is overlaid on the left side of the image, containing the text for the second block. A solid green vertical rectangle is positioned in the top right corner of the slide.

MAT has been shown to keep patients in treatment programs longer, increasing their chances of a long-term recovery.

Methadone & Buprenorphine Therapies

- ▶ Methadone and Buprenorphine (the active ingredient in Suboxone) are both opioids—human-made chemicals that are like opiates (medicines made from opium)
- ▶ Methadone was approved for opioid use disorder treatment in 1947 and Buprenorphine in 2002
- ▶ Used for opiate withdrawal management in inpatient settings and maintenance treatment in outpatient settings
- ▶ Given by a licensed provider and administered in oral form
- ▶ Behavioral health treatment is an important part of treatment

Methadone

- ▶ **Chemically unlike heroin or morphine, but works as an agonist for both**
 - ▶ Also used for the treatment of chronic pain
- ▶ Delivered in liquid or pill form in Opioid Treatment Programs (OTPs)
 - ▶ Can be diverted for street use by injection through large needles
- ▶ Long-term effects: 24 – 36 hours
- ▶ Responsible for some opioid overdose deaths, since Methadone accumulates in tissues before binding to plasma proteins
- ▶ Withdrawal develops slowly and is extremely difficult and prolonged

Buprenorphine

- ▶ An **opioid agonist** in low doses and an **antagonist** in high doses, often combined with Naloxone: Suboxone®
 - ▶ In this formulation, should the patient try to inject the drug (instead of taking it orally), they will theoretically go into withdrawal symptoms (but people have found ways around this)
 - ▶ Suboxone is delivered in a buccal film or pill
 - ▶ Less respiratory depression than Methadone
- ▶ Has a “ceiling effect” (at 32 mg) which makes overdose less likely—except when mixed with alcohol
- ▶ In 2017, the Food and Drug Administration approved Sublocade®, an injectable form of buprenorphine

Methadone & Buprenorphine Therapies

- ▶ The use of either chemical as part of opioid treatment is called Medication-Assisted Treatment (MAT) and has been recognized and accepted by the medical community for decades
- ▶ Methadone and Suboxone act as opioid agonists: They keep the client from experiencing opioid withdrawal symptoms (also called “dope sickness”) and block the euphoric effects should the client use heroin or another opioid, thus discouraging the client from continuing use
 - ▶ **Neither of these chemicals, when used as prescribed, will get the client high**
- ▶ Both chemicals allow the brain to heal from opioid misuse and provide opportunities for the client to address the underlying causes of their addiction

Naltrexone & Naloxone

- ▶ These opioids only have antagonistic properties; they will cause an opiate user to go into withdrawal (Naloxone) if administered while the person is using opioids or will block the effects of opioids (Naltrexone)
- ▶ **Naltrexone** (Vivitrol®) is a deterrent, and is used to prevent relapse by limiting cravings
 - ▶ Also blocks the euphoric effects of opioids, cocaine, and alcohol
 - ▶ Time-release injectable versions and implant versions are available
- ▶ **Naloxone** (Narcan®) is injected or used intra-nasally to reverse an opiate overdose

MAT & Incarcerated Clients

- ▶ Many prisons and jails have started providing MAT to clients, either during their entire stay, or in preparation for their release
- ▶ This includes screening all clients when they enter the system
- ▶ Clients who want MAT then need to be matched with the correct medication and dosage
- ▶ Medication alone is not the complete answer: Counseling and support services are important in the treatment process
- ▶ Pregnant clients should be given priority for MAT
- ▶ Correctional personnel are encouraged to form professional relationships with community-based providers to refer clients to upon discharge to ensure limited disruption in treatment
- ▶ Clients receiving MAT while incarcerated and who continue treatment upon release demonstrate a much lower re-arrest rate

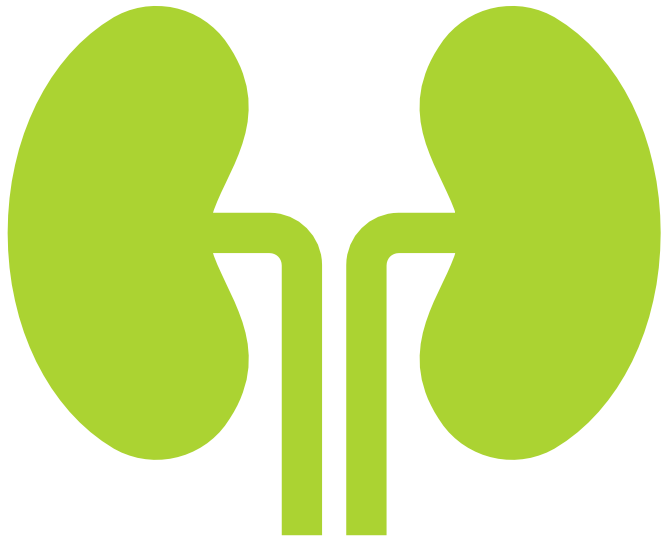
Drug Screens



Purpose of Drug testing

- ▶ **No form of drug testing is accurate 100% of the time**
- ▶ Drug testing can be a part of the therapeutic process, and should **not** be used punitively in therapeutic settings
- ▶ From a therapeutic standpoint, a drug test can be used to verify the client's honesty and provide opportunities for more effective treatment:
 - ▶ "I am glad that you consistently keep your appointments and you are working hard. I noticed that your UDS indicated that you have recently used cocaine. You mentioned to me last week and today that you stopped using weeks ago. Remember, I am not the police, so the results stay here, so help me understand what's going on."

Urine Drug Screens



- ▶ The cheapest and easiest-to-use form of drug testing
- ▶ There should be a testing protocol in place for your agency before you use these tests
- ▶ UDS have limited value if the person is not directly observed giving the sample
- ▶ Randomized sampling, as opposed to scheduled testing, is more likely to limit tampering

UDS: Point of Care

Point-of-Care [POC] urine drug testing (e.g., immunoassay) uses antibodies to locate metabolites of drugs the person may have used

The possibility of a false-positive (or a false negative) varies, so POC tests should be verified by lab tests (see next slide):
Do not make treatment or legal decisions based on a POC test alone!

Be aware that many chemicals/agents are available to add or substitute in a sample to create a false reading


Lab Testing

- ▶ Gas Chromatography/Mass Spectrometry Combined (GC/MS) is the industry-standard for drug testing
 - ▶ Very sensitive and accurate
 - ▶ Expensive and time-consuming
 - ▶ GC/MS can also provide levels of a drug in the sample
- ▶ Understand that levels can decrease and increase without the client consuming more of a substance between tests
 - ▶ This variation in levels depends on several factors, including the person's metabolism
- ▶ Once a specific cut-off for the test is established the test should only be read as **positive or negative**

How to 'Pass' a UDS While Using

36

- ▶ Use someone else's urine
- ▶ Use a urine substitute
 - ▶ Synthetic urine is available for purchase online
- ▶ Add a substance to the urine
 - ▶ Dishwashing detergent or other cleaners can be on the person's hand or finger and dipped into the sample
 - ▶ Always have the person wash their hands before (and after) providing a sample
- ▶ Attempt to dilute the sample by drinking a lot of water
 - ▶ Or dipping the sample cup in the toilet
- ▶ Taking vitamin supplements (B-complex vitamins are commonly used) to mask the presence of drugs



SUD,
LEGALLY-
INVOLVED
CLIENTS AND
MEDICAID

COVER VIRGINIA INCARCERATED UNIT (CVIU)

- ❑ The Cover Virginia Incarcerated Unit (CVIU) is the designated unit at Cover Virginia for assisting incarcerated individuals in applying, obtaining, and maintaining Medicaid healthcare benefits.
- ❑ There are 2 units within the CVIU:
 - ❑ The CVIU has an Eligibility Unit that is responsible for processing Medical Assistance applications, changes, renewals and ongoing case maintenance, and
 - ❑ The CVIU has a Call Center that accepts telephonic applications, case changes and case inquiries

Medicaid & the Incarcerated Person

The client must meet the following Medicaid eligibility requirements?

- Virginia residency
- Citizenship or immigration status
- Social Security Number (SSN) or proof of application for an SSN
- Institutional status requirement of being an inmate in a public institution
- Resources (if applicable) within resource limit
- Income within the income limit

What does Medicaid cover?

- Inpatient hospitalization. This means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who is admitted and receives room, board and professional services in the institution for a 24 hour period or longer, or is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another medical facility and does not actually stay in the institution for 24 hours.

The CVIU has 6 Types of Application Processing

1. **Standard/New Application Processing** – For incarcerated individuals without special circumstances or immediate release date
 2. **Expedited Application Processing** – For incarcerated individuals without Medicaid coverage who have an unforeseen and imminent hospital stay; OR has an upcoming hospital release or discharge
 3. **Pre-Release Application Processing** – For incarcerated individuals with active coverage under a 108 or 109 Aid Category code in which a partial review of active coverage occurs once the CVIU is notified of a Release Date within 45 days of release
 4. **Re-Entry Application Processing** – For incarcerated individuals who are: (1) not actively enrolled in Medicaid and, (2) scheduled to be released within 45 days of the application date
 5. **Renewal Application Processing** – The annual review of active Medicaid coverage
 6. **Emergency Medicaid Services Application Processing** – For Non-citizen incarcerated individuals who meet all Medicaid eligibility requirements other than alien status
- (The Medicaid aid category for incarcerated coverage is **108** or **109**)

How Do Individuals Apply for Medicaid Coverage While Incarcerated

Individuals may apply for Medicaid coverage with the assistance of correctional staff through any of the following:

- ▶ Call the Cover Virginia Incarcerated Unit (CVIU) Call Center at 1-833-818-8752
- ▶ Complete an online application at Common Help: www.commonhelp.virginia.gov
- ▶ Email the paper application to Cover Virginia Incarcerated Unit's eligibility inbox: cviu.eligibility@conduent.com. You may also fax the application to Cover Virginia's fax number: 1-888-221-9402.
- ▶ Mail the paper application to the Cover Virginia Incarcerated Unit:
Cover Virginia Incarcerated Unit
P.O. Box 1820
Richmond, Virginia 23218-1820
(Note: mailing may take longer than other methods of applying)
- ▶ Correctional staff may find additional information regarding the application process at the CVIU's website at www.coverva.org/cviu

CVIU

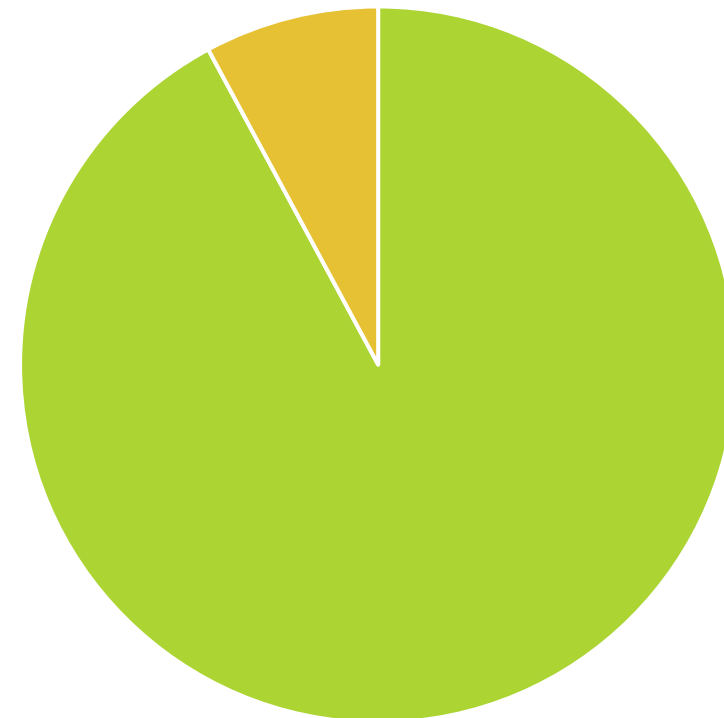
New Applications Received

- 24,480 Year To Date 2019
- 5,916 Year To Date 2020

Incarcerated Enrollment

- **Currently Enrolled – 20,764**
 - Enrolled in AC 108:
 - 19,131 (92.13%)
 - Enrolled in AC 109:
 - 1,633 (7.87%)

Enrolled



■ AC 108 ■ AC 109

Medicaid Enrollment and the Re-Entry Process: Access to Full Medicaid Benefits

- ▶ Doctor, hospital, and emergency services
- ▶ Prescription drugs
- ▶ Laboratory and X-ray services
- ▶ Maternity and newborn care
- ▶ Long-term care and support services
- ▶ Home health services
- ▶ Behavioral health services including addiction and recovery treatment services
- ▶ Rehabilitative services including physical, occupational, and speech therapies
- ▶ Transportation to Medicaid-covered services when no alternatives are available
- ▶ Family planning services
- ▶ Medical equipment and supplies
- ▶ Preventive and wellness services and chronic disease management services
- ▶ And more!

Medicaid Enrollment and the Re-Entry Process: Access to Addiction and Recovery Treatment Services (ARTS)

- ▶ Inpatient Detox
- ▶ Residential Treatment
- ▶ Partial Hospitalization
- ▶ Intensive Outpatient Programs
- ▶ Opioid Treatment Programs
- ▶ Office-Based Opioid Treatment
- ▶ Case Management
- ▶ Peer Recovery Supports

Community Providers: Assisting Individuals with Medicaid Enrollment



Call the Cover Virginia Call Center at 1-855-242-8282 (TDD: 1-888-221-1590)



Complete an online application at Common Help: www.commonhelp.virginia.gov



Complete an online application at The Health Insurance Marketplace: www.healthcare.gov



Mail or drop off a paper application to your local Department of Social Services (mailing may take longer than other methods of applying.)

Find your nearest local Department of Social Services by visiting:
<http://www.dss.virginia.gov/localagency/index.cgi>



Call the Virginia Department of Social Services Enterprise Call Center at 1-855-635-4370 (if you also want to apply for other benefits)

Community Providers: Helping Individuals Access Full Medicaid Benefits

- ▶ To help justice involved individuals access full Medicaid benefits or to see if they are still Medicaid eligible, community providers can help by contacting:
 - ▶ Emailing Provider Assistance:
provider.assistance@conduent.com
 - ▶ Calling the Virginia Medicaid Member Helpline: 804-786-6145
 - ▶ Asking the member to contact their Department of Social Services (DSS) Eligibility Worker
 - ▶ Virginia DSS Enterprise Call Center: 1-855-635-4370

Tele- Behavioral Health Basics

Tele-Behavioral Health

We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency

Tele-Behavioral Health: Clinician

- ▶ Have a space set up where you can connect with your client without being disturbed
- ▶ Your work-space should provide some privacy for your client
- ▶ Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health
- ▶ If conducting a group therapy session, educate clients on muting themselves unless they are speaking
- ▶ I recommend against using your personal phone, but sometimes this cannot be avoided
 - ▶ If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you

Tele- Behavioral Health: Clinician

You'll likely notice that the flow of clinical sessions will be slower than in-person

Be aware that you will likely need to speak slower than in person

Try to express empathy with your voice, especially when not connecting via video

Tele-Behavioral Health: Client

- ▶ Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions
- ▶ Test out your communications system (connectivity) prior to meeting with your counselor
- ▶ Most of us (counselors especially) don't like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

52

- ▶ A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)
- ▶ A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)
- ▶ A statement agreeing that the sessions will not be recorded by either party
- ▶ A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information
- ▶ A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

- ▶ A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves
 - ▶ This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required
- ▶ A statement describing how you will handle technical problems should they arise
- ▶ A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency
- ▶ A statement that you are continuing to maintain treatment records during this time

Documentation

- ▶ **If you don't write it down, it never happened**
- ▶ Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
- ▶ Record where the client says they are contacting you from
- ▶ Do this as quickly as possible following the session
- ▶ **Stick to the facts**; do not presuppose or assume anything
- ▶ See documentation as a necessary means to protect yourself, the people you serve, and your organization

References

- ▶ Avery, J.D. & Avery, J.J. (eds.). (2019). *The stigma of addiction: An essential guide*. Springer Publishing.
- ▶ Brasler, P. (2019). *High risk clients: Evidence-based assessment & clinical tools to recognize and effectively respond to mental health crises*. Eau Claire, WI: PESI Media & Publishing.
- ▶ Herron, A.J. & Brennan, T.K. (2015). *The ASAM essentials of addiction medicine, 2nd Ed.* American Society of Addiction Medicine. New York: Wolters Kluwer.
- ▶ Joudrey, P.J., Khan, M.R., Wang, E.A., Scheidell, J.D., Edelman, E.J., McInnes, D.K., & Fox, A.D. (2019). "A conceptual model for understanding post-release opioid-related overdose risk." *Addiction Science & Clinical Practice*, 14: 17. <https://doi.org/10.1186/s137722-019-0145-5>
- ▶ Morgan, O.J. (2019). *Addiction, attachment, trauma and recovery: The power of connection*. New York: W.W. Norton & Company.
- ▶ National Sheriff's Association & National Commission on Correctional Health Care. (2018). *Jail-based medication-assisted treatment: Promising practices, guidelines, and resources for the field*.
- ▶ Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for successful transition of people with mental or substance use disorders from jail or prison: Implementation guide (SMA)-16-4998*. Rockville, MD: Author.